MDR: M4-02-2615-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service, 12/10/01 through 12/21/01.
   b. The request was received on 03/13/02

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial TWCC 60
      1. EOBs
      2. HCFA 1500s
   b. There is no response to the request for additional documentation found in the file.
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome

2. Respondent, Exhibit II:
   Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/07/02. There is no Carrier initial or 14 day response to this medical fee dispute in the file.

III. PARTIES' POSITIONS

1. Requestor: Undated Letter:
   "We were denied payment for documentation of Procedure [sic] and it is our position we have followed the documentation of procedures (DOP) guidelines….We based our fair and reasonable charge for CPT Code 97799-CP for all the components required to carry our Chronic Pain program."

2. Respondent: No position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only (DOS) eligible for review are 12/10/01 through 12/21/01.

2. The amount billed per the TWCC-60 is $16,000.00.

3. The amount paid by the carrier per the TWCC-60 is $6,400.00.

4. The amount in dispute per the TWCC-60 is $9,600.00.

6. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

V. RATIONALE

Medical Review Division's rationale:

The Requestor has submitted a HCFA 1500 reflecting charges for CPT Code 97799-CP. The carrier denied the charges in dispute as "DOP – M – REIMBURSED PER THE INSURANCE CARRIER/S FAIR AND REASONABLE ALLOWANCE." The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed.

The provider's 14 day additional information response is not noted in the case file in accordance with Rule 133.307 (g) (3).

When determining whether or not additional reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. After review of the dispute file, no documentation was noted to support the services billed and the provider's additional 14 day information is not noted is the case file as requested on 06/07/02. Therefore, no additional reimbursement is recommended.

The above Findings and Decision are hereby issued this 22nd day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.